IAAP Interview- Doctor Specialist in Psychiatry Zelde Espinel (Colombia)

1. As it is a common practice in your country, you have spent an entire year of your medicine studies doing what it is called "a rural year" ("año rural"). Concretely you have spent this period of time in the south of Colombia, in the department of Amazonas, where the indigenous community is still present and numerous. Can you tell us where have you been and what communities of indigenous do you have work with?

   During my social service year ("año rural") I was one of 2 community physicians based in Puerto Nariño, in Amazonas, Colombia's most southerly department (state). Puerto Nariño is the second municipality of the Amazonas department of Colombia, located in an estuary along the shore of the Amazon River. The municipality has about 2,000 residents but the hospital serves the larger surrounding area, a catchment area of about 6,000.

   Puerto Nariño is an experimental ecological community that is entirely pedestrian and no motorized vehicles are permitted. Travel to the capital of Amazonas, Leticia, the only other Colombian municipality in the region takes place by motorized boats, traveling along the Amazon River.

   At the time I was there, there was no municipal water system; the copious tropical rains provided the fresh water needs. Also, electrical power was available only sporadically, usually for about 2 hours per day. The hospital was equipped with its own gas-powered generator to maintain the electrical needs around the clock.

   The indigenous peoples in the area were primarily Ticunas, Yagua and Cocama.

2. Which are the main differences in the practice of medicine in this kind of indigenous communities? Have you found anything blocking your interventions, such as some general rooted beliefs?

   One of the most interesting differences is the cultural tradition of childbirth, women prefer to have their children at home, delivering them in a traditional squatting position, often in the company of a midwife. During my social service year, I only delivered one baby at the hospital. Another difference is the preference for using traditional herbal remedies rather than prescription pharmaceuticals. One of the most remarkable differences from urban practice in Colombia and especially different from medical practice in developed nations is the almost complete absence of chronic diseases. The population is lean, physically active and their substance is rich in fish and complex carbohydrates. However, what was very prevalent was parasitic diseases and much of our work had a public health focus, emphasising childhood immunizations and pre-natal care.

3. Even when we guess that your experience there was based on general medicine, have you observed any specific mental problem in this kind of people? What sort of interventions in mental health have you done?

   There was very minimal expression of mental illness in the community during my time in Amazonas. There was a single episode of a psychotic break requiring referral to the capital of Leticia. Regarding substance use, there were occasional cases of alcohol abuse. However, this was limited due to the low level of income (most people could not purchase hard liqueur) and the most prevalent from of alcohol consumption involved locally produced fermented beverages (e.g. yucca wine). Only the small population of non-indigenous "colonos" ("whites" who had relocated to the area) had a slightly higher level of alcohol use.

4. We don't know if the armed conflict in Colombia has impacted the indigenous settlements, but if it did, have you notice any kind of posttraumatic reactions in them?

   Throughout Colombia indigenous populations in some areas have been targeted for displacement and subjected to many atrocities. In our studies with (Internally Displaced Persons (IDPs) who have resettled Bogota, we find very high rates of common mental disorders in internally displaced women with highest rates in those who are indigenous. However, during my time in Puerto Nariño the local population had fortunately not been affected by the armed conflict.

5. How about the resilience? Do you think indigenous people are more resilient?

   It's difficult to apply resilience terminology to this population. These populations represent last vestiges of the traditional hunter-gatherer populations and they are maintaining lifestyles that have endured for millennia. However, it would be appropriate to describe these indigenous people as resilient based on their abilities to maintain their traditional lifestyles (including native language, rituals, and cultural art forms) despite more than 400 years of contact and exploitive conquest by European conquistadores.

6. Do you identify any distinctive ability that therapists should have in their approach to indigenous people? What kind of personal benefits have you achieved with your work with this specific population?

   The most important qualities that health practitioners should have when approaching indigenous people is respect for cultural traditions and appropriate humility, acknowledging that professional preparation in Western medicine is insufficient to fully understand their lifestyles and worldview. My experience during my social service year immediately following medical school helped to form my decision to specialize in psychiatry – in a curious way. Living and working in this indigenous community provided the opportunity to observe a population free from chronic disease that exhibited robust mental health in contrast to urban populations elsewhere in Colombia. This influenced my desire to work both clinically and from a public health vantage on promotion of mental wellness.